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THE EFFECT OF MRS WATTS' TRIP TO FRANCE ON THE NATIONAL HEALTH SERVICE

Introduction

In the last ten years the European Court of Justice has delivered a series of consistent and important judgments on the application of the law regarding free movement of services and free movement of persons to health care.[1] Despite protests from some governments—especially those, such as the UK, running systems where health care is largely provided by state-owned institutions and where provision is rationed to save money—the Court has found that the institution paying for domestic health care, which may be an insurer or a government, is *prima facie* obliged to pay for treatment abroad under certain circumstances, notably where the care does not entail hospital treatment, or, even if it does, where that treatment cannot be provided domestically without 'undue delay'.[2]

For years the UK government disputed that these principles applied to the NHS, because of its unique character, by comparison with the largely private and decentralised health systems on the continent.[3] When it became clear that this position could no longer be sustained it changed the character of its defence, and began arguing for restrictive application. It sought a broad interpretation of the exceptions that Community law allows to all its general principles of free movement, and a narrow interpretation of 'undue delay'. These arguments were tested, and largely rejected, by the Court of Justice in *Yvonne Watts v Bedford Primary Care Trust, Secretary of State for Health*.[4] Both the patient-oriented

1 Case C-158/96 *Kohll v Union des Caisses de Maladie* [1998] ECR I-1931; Case C-368/98 *Vanbraekel v Alliance Nationale des Mutualités Chrétiennes* [2001] ECR I-5363; Case C-157/99 *Geraets-Smits v Stichting Ziekenfonds and Peerbooms v Stichting CZ Groep Zorgverzekeringen* [2001] ECR I-5473; Case C-385/99 *Müller-Fauré v Onderlinge Waarborgmaatschappij OZ Zorgverzekeringen and van Riet v Onderlinge Waarborgmaatschappij ZAO Zorgverzekeringen* [2003] ECR I-4509; Case C-56/03 *Inizan v Caisse Primaire d'Assurance Maladie des Hauts-de-Seine* [2003] ECR I-12403; Case C-193/03 *Betriebskrankenkasse der Robert Bosch GmbH v Bundesrepublik Deutschland* [2004] ECR I-9911; Case C-145/03 *Héritiers d'Annette Keller v Instituto Nacional de la Seguridad Social* [2005] ECR I-2529; Case C-466/04 *Manuel Acereda Herrera v Servicio Cántabro de Salud*, 15 June 2006.

2 See *Inizan, Müller-Fauré, Geraets-Smits* (all n 1). See also AP van der Mei, 'Cross-Border Access to Medical Care: Non-Hospital Care and Waiting Lists' (2004) 31 LIEI 57; G Davies, 'Health and Efficiency: Community Law and National Health Systems in the Light of *Müller-Fauré*' (2004) 67 MLR 94; M Flear, annotation of *Müller-Fauré*, (2004) 41 CML Rev 209; A Dawes '"Bonjour Herr Doctor": National Health Care Systems, The Internal Market, and Cross-Border Medical Care Within the EU' (2006) 33 LIEI 167; P Cabral, 'The Internal Market and the Right to Cross-Border Medical Care (2004) 29 EL Rev 673.

3 See UK arguments in *Geraets-Smits, Müller-Fauré* (all n 1).

4 Case C-372/04 *Yvonne Watts v Bedford Primary Care Trust, Secretary of State for Health* [2006] ECR I-4325; [2006] QB 667. For discussion of the proceedings before the national courts see Dawes (n 2) 175–8; J Montgomery, 'The Impact of EU Law on English Healthcare Law' in M Dougan and E Spaventa (eds), *Social Welfare and EU Law* (Hart Publishing, Oxford 2005) 145, 146–8.

content of the judgment, and the fact that it specifically addresses the NHS, mean that it will have considerable impact in the UK. As well as highlighting the pressure for structural reform of the NHS that Community law creates it also sketches the outline of future litigation on patients' rights.

The Facts

In 2002 Mrs Yvonne Watts was suffering from arthritis of the hips, her mobility was severely limited, and she was in constant pain. The waiting time for the necessary surgery in the area where she lived, Bedford, was around one year. She sought permission to go to France to have the operation, but Bedford Primary Care Trust refused. Given that her case was classified as 'routine', and the year's waiting time fell 'within the government's NHS plan targets', it was not an 'undue delay'.[5] According to Article 22(2) of Regulation 1408/71, and Article 49 EC, which prohibits restrictions on the cross-border provision of services, as interpreted by earlier judgments, where patients requiring hospital treatment[6] cannot obtain this domestically without 'undue delay' they must be granted permission to have the treatment abroad at the home authority's expense. This much is established law.[7]

Another examination of Mrs Watts in February 2003 concluded that her situation had deteriorated and she required surgery 'soon', which meant within three or four months. However, Bedford PCT said that the local waiting time for hip surgery had been reduced to three or four months, and therefore this could be complied with. There was, again, no question of undue delay, and no reason to grant her authorisation to go abroad.[8]

She went anyway, and had the surgery in March 2003, at her own expense, in Abbeville, France. Then she came back and requested reimbursement, which was refused. She had already begun judicial review of Bedford PCT's refusal to grant authorisation, and now she added a claim for the costs of her operation. The High Court found against her, ruling that the three or four month wait which applied after her second examination was not 'undue delay'.[9] She appealed to the Court of Appeal,[10] which referred a number of questions to the European Court of Justice.

5 *Watts* (ECJ) (n 4) [24]–[26].

6 For non-hospital treatment there is no authorisation requirement—patients may go abroad at will and claim reimbursement of costs (subject to any requirement that specialists only be seen after an initial consultation with a GP, where this is the practice domestically). The meaning of 'hospital treatment' remains open to debate. See works cited in n 2 above. For the amount of reimbursement, see p 163.

7 See n 2 above.

8 *Watts* (ECJ) (n 4) [30].

9 Ibid [30]–[34]; *R v Bedford Primary Care Trust, ex parte Watts* [2003] EWHC 2228, [2003] 3 CMLR 23.

10 *R v Bedford Primary Care Trust, ex parte Watts* [2004] EWCA 166, [2004] 2 CMLR 23.

Judgment and Commentary

What is 'Undue Delay'?

The first question that the Court dealt with was the meaning of 'undue delay'. It reiterated that whether one looked on the refusal to authorise as a restriction on the free movement of services (it discouraged Mrs Watts from receiving medical services abroad) within Article 49, or as a matter within Regulation 1408/71, on the co-ordination of social security systems, would make no difference to the answer.[11]

One consideration was the factors that need to be taken into account in deciding what is 'undue'. Bedford PCT clearly interpreted this to refer to delays exceeding the norm for the NHS, or the government guidelines.[12] In other words they looked at it in the national and institutional context. By contrast, Mrs Watts preferred an interpretation which focused exclusively on her medical needs and situation. The Court largely went with Mrs Watts.[13] It quoted Article 20 of Regulation 883/2004, which replaces 1408/71.[14] This new regulation provides that authorisation must be given when treatment cannot be provided 'within a time-limit which is medically justifiable, taking into account his/her current state of health and the probable course of his/her illness'.[15] The emphasis is clearly on the patient, rather than the system. Indeed, the Court's final word on this question was that refusal is only justified where the wait for treatment 'does not exceed the period which is acceptable on the basis of an objective medical assessment of the clinical needs of the person concerned in the light of all the factors characterising his medical condition at the time when the request for authorisation is made or renewed, as the case may be'.[16] The Court also referred to the finding in earlier cases that the influence of the medical condition on the patient's wider life, notably their work, could be relevant.[17] 'Undue delay' for a hairdresser with an elbow condition may be briefer than for some other people.

The UK government argued that the effect of this patient-centred, needs-based approach to provision of health care would be to undermine the national authorities' capacity to manage the system via the use of waiting lists.[18] Such management is intended to ensure that the most urgent cases are treated first, and to even out the flows of patients

11 *Watts* (ECJ) (n 4) [60].

12 See n 5 above.

13 *Watts* (ECJ) (n 4) [62]–[79].

14 Regulation 883/2004 is in force, but will need to be applied only when its implementing regulation comes into force (See Case C-205/05 *Nemec,* judgment of 9 November 2006). At the moment there is a proposal for such a regulation on the table, COM (2006) 16 Final. With respect to the subject matter of the discussion above Regulation 883/2004 does not make significant changes to Regulation 1408/71. The comments on the latter are therefore transferable to the former.

15 *Watts* (ECJ) (n 4) [65].

16 Ibid [79].

17 Ibid [62].

18 Ibid [75].

to enable hospital capacity to be used efficiently. However, the Court rejected these arguments. Such a use of waiting lists was only legally problematic if the waiting time was so long that it could not be clinically justified, and that for individual patients it was medically indefensible.[19] Was the UK government really arguing for its right to act against the medical interests of patients waiting for treatment? It was, but it lost the point, and it can do so no longer.

The Procedural Rights of Patients Seeking Permission for Treatment Abroad

Prior authorisation for hospital treatment abroad is usually a condition of reimbursement, and the Court accepts this as legitimate,[20] as it provides a degree of predictability for the funding system or institution. However, the risk of an authorisation procedure is that it will be slow and bureaucratic and lack transparency. Patients will be refused for reasons that are difficult to ascertain and so difficult to challenge, and it will not be possible to obtain or challenge decisions within the time that the medical condition necessitates. In order to minimise the obstacles to treatment abroad the Court therefore laid down a few principles, largely restatements from earlier cases, but with some expansion.[21]

Firstly, the criteria for authorisation must be objective, non-discriminatory, and known in advance, 'in such a way as to circumscribe the exercise of the national authorities' discretion, so that it is not used arbitrarily'.[22] This is to be a rule-based procedure, not entirely without discretion, but that discretion is severely limited. Primary care trusts are therefore obliged to state publicly the conditions under which they will grant authorisation.

The central condition is of course that domestic treatment cannot be provided domestically without undue delay.[23] However, this is hardly a precise measurement, and its mere statement does not enable patients to know their position clearly. Therefore it would be wise and helpful and in the spirit of the judgment for health authorities to set out what are considered to be acceptable maximum time periods for certain common treatments, while also stating, in order to remain in compliance with the law, that each

19 Ibid [75]–[76].

20 Ibid [108]–[113]; although there is no obligation to wait for the completion of legal challenges to a refusal to authorise before going abroad for treatment. It is simply that the patient bears the financial risk of failure in court. This was the situation of Ms Watts. See *Vanbraekel* (n 1).

21 Ibid [114]–[123].

22 Ibid [116].

23 An additional consideration is whether the treatment sought abroad is 'among the benefits provided for by the legislation of the Member State on whose territory the person resides'; *Watts* (ECJ) (n 4) [56]. The NHS does not have to pay for treatment to which the patient would not be entitled in the UK. It may not always be easy to establish whether a given treatment, which may *in fact* not be available in the UK, or not in the patient's area, is within this description. If the patient *would be* entitled to the treatment, *were* it available, is that sufficient? The issue did not arise in this case. See *Inizan* (n 1); Montgomery (n 4) 153.

situation will be assessed in the light of individual circumstances so that particular suffering or difficulty experienced by a patient may reduce (but not increase) that period.[24] Given that these time periods are required to be based primarily on objective clinical factors, it would obviously make sense if they were the same nationally. It would therefore be a good idea to have central intervention or guidelines. Actually, it is hard to think of any reason why 'undue delay' should vary significantly from country to country.[25] It probably will, and governments will probably not look at other states in making their determinations. However, it is certainly open to lawyers to do so when arguing for their clients.

Secondly, the procedure must be easily accessible, decisions must be made in a reasonable time, and they must be challengeable in judicial or quasi-judicial proceedings.[26] In the light of the accessibility requirement it may be unreasonable to expect patients to provide arguments or evidence from specialists. It may be that if they make a request, and state why they feel they need treatment more quickly, it is for the authority to arrange a speedy and independent medical assessment of their situation. It may be difficult and/or expensive for individual patients to have to accumulate reports from specialists to support their case.

This raises another important issue. The Court found that courts faced with challenges to decisions must be able to seek the advice of objective and impartial experts.[27] The clear point here is that doctors who may have personal or institutional loyalty to the authority making the decision should not have the last word. It may be that professional ethics require doctors to make objective individual assessments even if these result in a decision which is expensive and undesirable for their employer or the institution where they work, or even for other patients on a waiting list. Nevertheless, the reality is that pressure can be exerted to interpret medical necessity in a particular way and—the greater risk—there can also be an institutional culture which takes a particular view of what is acceptable and what is not. The Court wants to get away from the question of what Bedford PCT thinks is acceptable, and move towards the question of what modern medical science thinks is acceptable.[28] This may entail evidence from experts who clearly have no affiliations that might complicate their position. There is also no reason why the evidence of NHS doctors should take precedence over the opinions of the foreign doctors to which the patient wishes to go.[29]

The impact of this may be significant. The High Court and the UK government may take the view that three to four months of constant pain does not comprise an undue

24 *Watts* (ECJ) (n 4) [119].
25 See nn 28 and 29 below.
26 *Watts* (ECJ) (n 4) [116].
27 Ibid [117].
28 *Geraets-Smits* (n 1) [91]–[98].
29 Montgomery (n 4) 151–2 and 155.

delay, but it is hard to see how that view can be supported if one looks from a medical and personal point of view, rather than thinking about the institutional interests of Bedford PCT or the NHS as a whole, or about what is normal in the UK. Most people, most doctors in the developed world, and many Member States, would regard it as unacceptable to leave anyone in constant pain for a third of a year. It will not be difficult to find eminent medical experts to testify that someone in Mrs Watts' position should have had her operation within days or weeks, and that any delay risked further harm to her health. Indeed, the fact that her health did deteriorate between the initial assessment in October and that in February may indicate that even these three or four months did in fact, in retrospect, comprise an undue delay. In short, if courts have to look at the medical needs of patients rather than the structural needs of the NHS then an entire national medical culture, which has somehow come to find that it is normal and acceptable to wait in pain and disability for months for treatment, may find itself under attack.

The Extent of Reimbursement: How Much does the NHS have to Pay?

The final major issue in the case concerned the cost of the treatment. Even if the NHS was in principle liable for the costs of treatment abroad, there remained questions concerning the precise extent of this.

A minor issue was the ancillary costs of treatment abroad, such as travel and lodging. The Court found that a state is only obliged to reimburse these where it reimburses equivalent costs for those being treated domestically.[30] This means that there will remain a cost burden for those being treated abroad, and in some circumstances a significant one, since one may expect travel and ancillary costs to be higher, and domestic coverage of equivalent costs is unlikely to be complete.

Regarding the costs of the medical treatment itself, the starting point is that under Regulation 1408/71 patients authorised to receive treatment abroad are entitled to the same benefits-in-kind as those insured in that country.[31] Thus if French patients (or their insurance companies) only have to pay 25% of the cost of their treatment to their providers, the same would apply to Mrs Watts. The French state or health authority,[32] which foots the rest of the bill, is entitled to claim reimbursement of this from the UK via a long-established procedure laid down in Regulation 1408/71. This takes place entirely without any reference to UK tariffs or costs of treatment.[33] Similarly, if a citizen of another

30 *Watts* (ECJ) (n 4) [142]. See also *Herrera* (n 1).

31 Articles 22 and 22a. These will be replaced by the similar Article 20 of Regulation 883/2004.

32 Or an insurance fund which has block contracts with care providers, rather than paying per treatment; see *Geraets-Smits* and *Müller-Fauré* (n 1). In some ways National Insurance in the UK is similar to this. See Vatzopoulos, 'Health Law and Policy: The Impact of the EU' in G de Búrca (ed), *EU Law and the Welfare State* (OUP, Oxford 2005) 111 for further explanation.

33 See Article 36 Regulation 1408/71; Implementing Regulation 574/72. These will be replaced by Article 35 Regulation 883/2004; COM (2006) 16 Final, Arts 61, 62 and Annex 3.

Member State received authorisation from their home state to come to the UK for treatment, then since the NHS provides treatment free to its patients—it is an entirely benefit-in-kind system—he or she would also receive free treatment, with the difference that the NHS would subsequently bill his or her home state.

However, in many countries hospital treatment is not provided on a benefit-in-kind basis. A large part, or the whole, of the cost of the treatment is paid to the provider by the patient or their insurer. The migrant patient therefore receives a bill, as did Mrs Watts. The obligation of the home state towards this bill is not covered by Regulation 1408/71, and is decided by Article 49 and free movement of services. Consistently with this, the guiding principle is non-discrimination between domestic and foreign services, and the obligation of the home state towards the bill depends on the nature of domestic coverage. The general approach is that the principles of domestic coverage must be applied to that bill. Thus, if the domestic system provides treatment entirely free of charge, as in the UK, then the *prima facie* obligation is to reimburse entirely any bill that the patient receives (or of course pay it directly).[34]

However, in an important restriction the Court found that the UK obligation to Mrs Watts could not take its total liability above the cost of the equivalent treatment under the NHS.[35] Thus if the operation would have cost the NHS three thousand pounds, and the UK was liable to the French authorities for two thousand pounds under the Regulation 1408/71 procedure, then it would be obliged to pay Mrs Watts no more than one thousand pounds, even if the bill that she in fact received was greater. To decide otherwise, the Court found, would be to entitle patients going abroad to greater coverage than those staying at home.[36]

This is a very insurance-minded perspective. One could just as well argue, as Mrs Watts did, that since the NHS covers the cost of domestic treatment in full then the obligation should be to cover the cost of foreign treatment in full too. Bearing in mind that a patient is only given authorisation to go abroad when the domestic system fails to treat them within a medically acceptable timeframe it is hard to see why they should be penalised financially. There is an interesting tension here between the patient-centred smooth co-ordination approach under Regulation 1408/71, which dictates that the home state pays for the foreign treatment at the foreign rate, and if that is expensive it is bad luck, and the fair trade approach under Article 49, which says that the cover for foreign treatment should be no less, but also no greater, than that extended to the domestic equivalent. They complement each other in a sometimes inconsistent way; the patient who goes to a very expensive state which provides benefits-in-kind may receive treatment

34 Problems may arise if domestic costs are partially reimbursed. If 90 per cent of a domestic hospital bill is reimbursed, must 90 per cent of a foreign bill also be paid, or is the amount also paid under Regulation 1408/71 to be taken into account, so that 90 per cent of the total cost is paid?

35 *Watts* (ECJ) (n 4) [131].

36 Ibid [132].

that is more expensive than the domestic equivalent but his home state will still have to pay, as it will fall within Regulation 1408/71. On the other hand, if he receives the same treatment, at the same cost, in a state with an insurance-based system, and is billed for it, then he will receive reimbursement only up to the UK cost.

How important this limit is in practice depends partly on the relative costs of UK and foreign treatment. It may be that the cost of treatment within the NHS is relatively high compared with that in many other Member States, in which case the limit may not often bite. The more important effect of the limit may turn out to be the pressure that it exerts on the NHS to quantify the cost of the treatments that it provides. Under the current system of public funding of hospitals it may not always be possible to say what the cost is of a given operation, or at least the authorities may not know.[37] Alternatively, where the NHS does attribute costs to particular procedures these may be highly challengeable; have they fairly factored in infrastructural costs, for example? Were the NHS to price its operations using only marginal cost (the cost of every additional operation) and not considering also the broader cost of creating and operating a hospital, this might make prices, and therefore reimbursement, artificially low.

In order to avoid having to write a blank cheque to every patient going abroad, the NHS does now need to establish the costs of medical procedures. Further, these costs need to be objectively and transparently established and made publicly available. Not only will they be relevant to the patient's choice of destination country, but the extent of reimbursement should be seen as falling within the procedural obligations discussed above, and must therefore be knowable in advance.

However, fixing a price is likely to be a process open to legal challenge and involving many controversial and difficult assessments. Indeed, part of the economics and logic of a national health system is that budgeting is not done in terms of the cost of each procedure, and that this does create certain efficiencies. Once each treatment is attributed a price, the behaviour and organisation of the NHS is likely to become significantly more like that of private-sector or insurance funded medical providers.[38]

Consequences for Private Health Care Providers in the UK

Finally, one may note that *Watts* may have a major impact on these private providers. If the NHS is obliged to pay for a patient to go abroad for treatment then it seems petty

37 One might think that some form of price list must exist, so that the NHS can bill other Member States for the cost of treating their citizens under the Regulation 1408/71 procedure, including emergency treatment. See *Müller-Fauré* (n 1) 104–8. However, many states have agreements whereby they pay lump sums per year, or even do not pay at all: the amount of cross-border benefit-in-kind treatment does not justify a complicated administrative apparatus, and often cancels itself out between states; see F Pennings, *Introduction to European Social Security Benefits* (3rd edn Kluwer, The Netherlands 2001) 148.

38 See G Davies, 'The Process and Side-Effects of Harmonisation of European Welfare States', Jean Monnet Working Paper 02/06 (www.jeanmonnetprogram.org) 22.

and nonsensical to refuse to pay for them to be treated at a private UK hospital, simply because this is an internal situation and Community law does not apply. It is perhaps not surprising that the UK government's policy of using private hospitals to reduce waiting lists has developed since the late 1990s in parallel with the flow of European judgments on free movement of patients. One possible effect of *Watts* is that patients will receive authorisation to go abroad, and then obtain consent to in fact have the replacement treatment done at a private hospital in the UK. Why should Bedford PCT care, if the cost to them is no greater and they have to pay for the treatment outside their own hospital anyway?

Perhaps they should care because of the risk of the flow increasing dramatically. While many patients may choose to wait rather than going abroad, the option of being treated domestically and privately will be more attractive. Seeking authorisation for foreign treatment might, depending on the state of waiting lists, be a way of leveraging quicker private treatment at home. From the other side, an increase in the number of patients being treated at public expense in private institutions in the UK may encourage foreign health care providers to establish institutions in the UK. Pressure for increased private provision may then come from the provider side too, using their capacity to reduce waiting lists as a public relations tool.[39]

Conclusions

There are several themes in which *Watts* plays a part. One is the liberalising pressure of free movement, which leads to the restructuring of public institutions. Community law has received much criticism for its alleged imposition of market philosophy in this way.[40] Perhaps one should note however that *Watts* and the cases which precede it only affect UK hospitals insofar as they are unable to provide treatment without undue delay. If the NHS offered operations within a time corresponding to patients' medical needs, *Watts* would have no effect.

The second theme is the gradual development of social rights in Community law, in an attempt to balance the claimed market bias. It will be suggested that *Watts* almost establishes a right to adequate medical care—if your state cannot provide it then it must pay for you to have it elsewhere.[41] This is not a right written into many constitutions, and it is controversial whether the Community should be the source of it, but nor is it something that is easy to reject.

39 Ibid 24. The Treaty also applies to medical services offered by foreign providers in the UK, but on the basis of establishment rather than services. The consequences of this are unclear. See eg Case C-55/94 *Gebhard* [1995] ECR I-4165, para 37, but cf Case C-70/95 *Sodemare* [1997] ECR I-3395. Note however that in this latter case there was no question of paying for Italians to go to care institutions abroad.

40 See eg F Scharpf, 'The European Social Model: Coping with the Challenges of Diversity' (2002) 40 JCMS 645.

41 A Kaczorovska, 'A Review of the Creation by the Court of Justice of the Right to Effective and Speedy Medical Treatment and its Outcomes' (2006) 12 ELJ 345; Montgomery (n 4) esp 154–5.

Thirdly, and most importantly in practice, the Court's emphasis on legalisation of the relationship between patient and domestic institution will create a flurry of law suits. In emphasising the obligation on the institution to be objective and transparent, and the right of the patient to access practical and accessible enforcement mechanisms, the Court is on the one hand continuing the Community law emphasis on domestic enforcement, which has been a theme of recent years, and on the other aligning itself with broader social trends towards individual empowerment against the state.

Lastly, the relatively unusual level of detail in *Watts* suggests that the case law has reached a point of maturity where we might expect it to be translated into legislation, and sure enough a proposal from the Commission on patients' rights and mobility is expected in 2007 and discussion regarding co-ordination of health systems via the OMC or legislation has taken off at Community level.[42] It will be interesting to see whether this turns out to be a first step towards wider Community harmonisation in the cause of a European-wide market for health care services.[43] That would have complex and politically difficult effects on the social, economic and medical aspects of health care provision, as well as on broader European integration and society.[44]

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42 See 'Follow-up to the high level reflection process on patient mobility and healthcare developments in the European Union', Communication from the Commission, COM (2004) 301; Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions, 'Modernising social protection for the development of high-quality, accessible and sustainable health care and long-term care: support for the national strategies using the "open method of coordination"', COM (2004) 304. Communication from the Commission 'Consultation regarding Community action on health services', SEC (2006) 1195/4.

43 Dawes (n 2) 178–80; Davies (n 37) 39–42.

44 Davies, ibid.